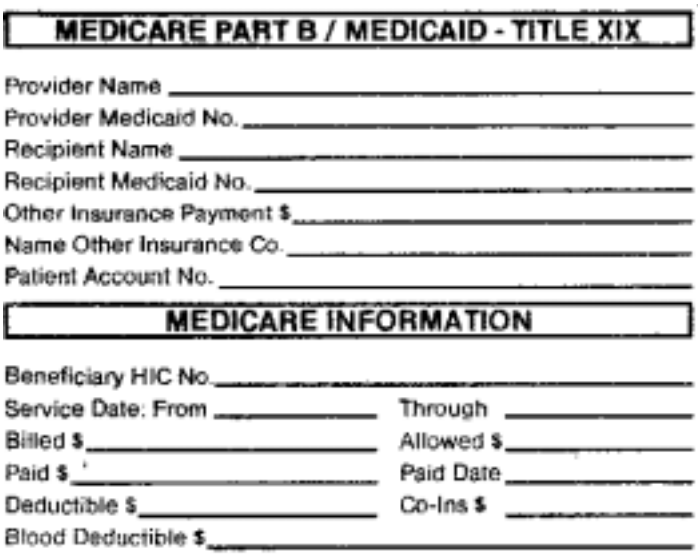
SECTION 7
INSTRUCTIONS FOR COMPLETING THE MEDICARE PART B CROSSOVER STICKER

The Medicare Part B sticker should be legibly printed by hand or electronically. Complete the Medicare Part B/Medicaid-Title XIX sticker as follows and attach it to the Medicare Remittance Advice/Explanation of Medicare Benefits so it does not cover the recipient's identifying information or claim payment information. Completed crossover claims should be mailed to:

Verizon Information Technologies
PO Box 5600
Jefferson City, MO 65102


MEDICARE PART B / MEDICAID - TITLE XIX

Provider Name _____
Provider Medicaid No. _____
Recipient Name _____
Recipient Medicaid No. _____
Other Insurance Payment $ _____
Name Other Insurance Co. _____
Patient Account No. _____

MEDICARE INFORMATION

Beneficiary HIC No. _____
Service Date: From _____ Through _____
Billed $ _____ Allowed $ _____
Paid $ _____ Paid Date _____
Deductible $ _____ Co-Ins $ _____
Blood Deductible $ _____

Field number & name		Instruction for completion
1.	Provider Name	Enter the provider's name as shown on the provider label.
2.	Provider Medicaid Number	Enter the provider's nine-digit Medicaid number.

3.	Recipient Name	Enter the patient's name exactly as shown on the ID card. (last name, first name).
4.	Recipient Medicaid Number	Enter the recipient's eight-digit identification number as shown on the ID card.
5.	Other Insurance Payment	Enter the amount paid by any other insurance.
6.	Name Other Insurance Company	If an insurance amount is shown on line 5, enter name of insurance company. If the insurance plan denied payment, enter the plan name and attach a copy of the insurance denial to the claim.
7.	Patient Account Number	For the provider's own information, a patient account number may be entered here.
8.	Beneficiary HIC Number	Enter the patient's HIC Number as shown on the Medicare card.
9. & 10.	Service Date: From and Through	Enter the date of service. If multiple dates of service are shown on the Medicare RA/EOMB for a single claim, enter the first chronological date of service in "From" field and the last chronological date of service in "Through" field.
11.	Billed	Enter the total Medicare billed amount for the claim. Use the amount shown on the Medicare RA/EOMB.
12.	Allowed	Enter the total Medicare allowed amount for the claim. Use the amount shown on the Medicare RA/EOMB.
13.	Paid	Enter the total amount paid for the claim by Medicare.
14.	Paid Date	Enter the date shown at the top of the Medicare RA/EOMB.
15.*	Deductible	If any deductible was applied on this claim, enter the amount due in this field.

16.*	Co-insurance	Enter the total amount of co-insurance due on this claim.
17.	Blood Deductible	If there is a blood deductible due, enter that amount.

* Do not enter deductible and coinsurance amounts in the same field. They must each be listed in their own field.

MEDICARE BILLING TIPS

BILLING WHEN MEDICARE HAS A DIFFERENT PATIENT NAME THAN MEDICAID

On the paper crossover sticker, show the Medicaid name first with the Medicare name in parenthesis behind it, e.g. Smith, Roberta (Bobbi) or Jones (Masters), Gerald.

CLAIMS NOT CROSSING OVER ELECTRONICALLY

If none of a provider's Medicare claims are crossing over to Medicaid electronically, contact Medicaid to see if the provider has a Medicare number on file and that it is the correct one. Although Medicare advises that a claim was forwarded to Medicaid for processing, this does not guarantee that Medicaid received the claim information or was able to process it. If there is a problem with the claim or the recipient or provider files, the claim will not process. **A provider should wait 60 days from the date a claim was paid by Medicare before filing a crossover claim with Medicaid.** If a claim is submitted sooner, it is possible that the provider will receive a duplicate payment. If this occurs, the provider must submit an Individual Adjustment Request form to have Medicaid take back one of the payments.

TIMELY FILING

Claims initially filed with Medicare within Medicare timely filing requirements and that require separate filing of a crossover claim with Medicaid must meet the timely filing requirements by being submitted by the provider and received by the Medicaid agency within 12 months from the date of service or six months from the date on the provider's Medicare Explanation of Medicare Benefits (EOMB), whichever date is *later*. The counting of the six-month period begins with the date of adjudication of the Medicare payment and ends with the date of receipt.

BILLING FOR ELIGIBLE DAYS

A provider may attempt to bill only for eligible days on the Medicaid Part B claim form. In order for crossover claims to process correctly, a provider must bill all dates of service shown on the Medicare EOMB. The Medicaid claims system will catch those days' claims containing ineligible days and the claim will be prorated for the eligible days only.

ADJUSTMENTS

If Medicare adjusts a claim and Medicaid has paid the original crossover claim, then the original claim payment from Medicaid should be adjusted using an Individual Adjustment Request form with both Medicare EOMBs attached to the form.